National Conference of State Legislatures

STATE HEALTH NOTES

FORUM FOR STATE HEALTH POLICY LEADERSHIP

APRIL 19, 2004 VOLUME 25, NUMBER 418

Better Jobs Better Care: Retaining Long-Term Care Workers

Good direct-care workers – nursing assistants, home health aides and personal care attendants – are essential to high-quality, long-term care for seniors and the disabled because they provide the bulk of hands-on, paid care for these populations. Unfortunately, there is a severe shortage of these workers, and it will likely worsen as the baby boomers age (see chart, page 5).

The Bureau of Labor Statistics estimates that personal and home care assistance will be the fourth-fastest growing occupation by 2006, with a dramatic 84.7 percent growth rate. But if the need for workers will soar, the supply will not. The number of people who need long-term care is expected to increase much faster than the supply of people between ages 20 and 64, who make up most of the direct care workforce.

Currently, direct care work is physically and emotionally demanding, and working conditions are often unfavorable. Workers leave the field because of low wages, lack of benefits, limited opportunities for advancement, lack of appropriate training, poor public image, lack of respect and exclusion from patient-care planning. "Annual turnover rates are 70 percent," said Debra Lipson, deputy director for the demonstration project Better Jobs Better Care, citing a study by the American Health Care Association. "In other words," she said, "two out of three direct-care workers leave their jobs in the course of a year."

The median hourly wage for direct-care workers in 2002 was $8.70, according to the U.S. Bureau of Labor, but there is great discrepancy between wages for workers in institutions and those who work in personal homes. "In a hospital, an aide gets about $18,000 [a year]. In a nursing home, they may get $15,000 and, in a residential care home, it's like $12,000, which has got to change," stated Lipson. A March 2004 study from the Paraprofessional Healthcare Institute and the North Carolina Department of Health and Human Services found that 35 states (out of the 44 responding states) considered current worker vacancies a serious issue.

A BETTER WAY

To reduce high vacancy and turnover rates among direct-care staff in all long-term care settings and, in the end, improve the quality of care, The Robert Wood Johnson Foundation and The Atlantic Philanthropies have funded a 4-year $15.5 million research and demonstration program called Better Jobs Better Care.

The Institute for the Future of Aging Services at the American Association of Homes and Services for the Aging is the program office for Better Jobs Better Care, providing technical assistance to the grantees in partnership with the Paraprofessional Healthcare Institute, a non-profit health-care employment development and advocacy organization.

The organization is using two types of grants – for demonstration programs and research and evaluation projects – to identify which interventions appear to be most effective in recruitment and retention of direct-care workers, said Lipson. In July 2003, the project awarded up to $1.4 million to each of five grantees in Iowa, North Carolina, Pennsylvania, Oregon and Vermont.

Over the next three and a half years, the demonstration projects will test innovative strategies to improve the recruitment and retention of direct-care workers. These strategies include training for direct-care workers and their supervisors and organizational cultural change for direct-care workers to be much more involved in patient care. "The aides spend the majority of their time with long-term care clients, but oftentimes their input is ignored," said Lipson.

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State Health Notes is supported in part by a grant from the Robert Wood Johnson Foundation.

BEHAVIORAL HEALTH NEWS

Buprenorphine: Can Addiction Treatment Be Mainstreamed?

When the Food and Drug Administration (FDA) approved buprenorphine in 2002 for treating opioid dependence, it raised the hopes of addiction treatment experts everywhere. First, it was thought that the new drug would both "medicalize" treatment for chemical dependence and would make it much more widely available, by allowing addicts to be treated by primary-care doctors in their offices. Also, by bringing more doctors' offices into the treatment arena, the public might begin to understand that addiction is a complex, chronic medical condition, not a simple lack of willpower.

Things haven't turned out quite that way. Government regulations and physician reluctance to treat addicts in their offices have severely limited access to the new drug (which not only treats dependence on heroin, but on opioid-based prescription drugs such as OxyContin). The National Institute for Drug Abuse estimates that more than 1 million Americans are addicted to opiates, but it's estimated that buprenorphine is being given to only a few thousand addicts nationwide. Nevertheless, advocates are working to eliminate barriers to its usage, and it's hoped that buprenorphine will one day be an underpinning of addiction medicine.

Treating drug addiction through prescription medication began in the 1960s with methadone maintenance, in which addicts visit clinics daily to receive single doses of methadone, an agonist medication. Agonists are chemicals that produce euphoria because they bind to and stimulate opiate receptors in the brain. *An*tagonists, in contrast, block the effects of opiates by blocking receptors without stimulating them.

Derived from thebaine (a constituent of opium), buprenorphine significantly reduces patients' craving for heroin. The drug is clinically attractive because it is a partial agonist – it stimulates opiate receptors in the brain to produce the effects associated with opiates, but it produces less euphoria. Buprenorphine also causes a significantly lower degree of respiratory depression, the slowing of breathing that makes heroin overdoses so dangerous.

Also, bupenorphine is long-lasting because it is released slowly from the brain receptor. Therefore, it's possible to give patients buprenorphine every other day, rather than daily as with methadone. Some studies suggest that buprenorphine's withdrawal effects are less severe than methadone's.

Buprenorphine has some potential for misuse because it produces the feeling of being "high." Therefore, buprenorphine is subject to diversion, which makes it unsuitable for use as a take-home medication.

To address this, drug makers combined buprenorphine with naloxone (an opiate antagonist) to produce the combination tablet Suboxone. If an addict dissolved Suboxone and injected it intravenously, the naloxone would produce unpleasant withdrawal symptoms. However, naloxone does not produce these effects when the combination tablet is taken sublingually, beneath the tongue. Suboxone was approved by the FDA in 2002.

LIMITS ON USAGE

When the FDA approved buprenorphine, it did so under strict conditions for distribution. Potential prescribers must undergo eight hours of training, after which they must send their credentials to the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA then issues the doctors a buprenorphine-specific identification number from the Drug Enforcement Administration.

SAMHSA announced in January 2003 that persons seeking physicians who can prescribe buprenorphine, can obtain information online at buprenorphine.samhsa.gov.

As of September 2003, only about 2,000 doctors nationally had been cleared to prescribe buprenorphine. Right from the start, there were problems with dissemination. The FDA approved the drug in October 2002, but manufacturers did not ship it out to pharmaceutical warehouses until early January 2003.

A more important issue is low interest among primary-care physicians. Doctors who do treat addiction say lack of training, concern about having an "unsavory clientele," difficulty in locating pharmacies that will stock the drug and "taking on a complicated sideline that doesn't pay well" explain why some physicians are not interested.

A third barrier is a federal rule that limits physicians who prescribe buprenorphine to 30 buprenorphine patients per practice. The rule was designed to prevent buprenorphine "mills," but it has prevented large "practices" such as The Johns Hopkins School of Medicine in Baltimore, Maryland, from becoming treatment centers. Then there are the cost barriers: most state Medicaid programs and most private insurance plans do not cover buprenorphine. Doctors say the retail cost is $5 to $10 per patient, per day.

Nevertheless, advocates are taking steps to make buprenorphine more widely available. Last November, Sen. Orrin Hatch (R-Utah) introduced legislation to lift the 30-patient limit on group practices. The bill is in the Judiciary Committee.

SAMHSA also is trying to increase the number of prescribers by creating a mentoring program for those who are considering prescribing; establishing an online bulletin board for prescribers; educating pharmacies; and expanding training beyond physicians to addiction specialists, psychologists, therapists and social workers.

Meanwhile, scientists are coming up with new and improved iterations of the drug. A small study published in February by researchers at Johns Hopkins indicates that a new form of buprenorphine may block the effect of opioid drugs and prevent withdrawal symptoms for as long as six weeks.

In the end, it may be that the new drug will be most helpful to persons who are addicted, but otherwise healthy, employed, in no legal trouble, with good family support and good relations with offspring, and no co-occurring mental illness. Such a person may already see a physician who could provide treatment with buprenorphine.

However, an addict who has health problems, is unemployed, has legal trouble, has no family support, has offspring in foster care, and has a co-occurring mental illness is less likely to avail him- or herself of the office-based model of treatment. This person needs the services that are usually provided at a drug treatment facility – health care, job skills training and employment services, criminal justice interventions, parenting training, and mental health services. When all these factors are considered, it seems unlikely that methadone maintenance – and the social services that typically accompany it – will go out of fashion any time soon. *AC*

HIGHLIGHTS

MEDICAID

Formularies to Continue

A U.S. Appeals Court for the District of Columbia ruled April 2 that Michigan could continue its use of a drug formulary when prescribing drugs to low-income patients enrolled in public programs. In a unanimous three-judge ruling, the Appeals court rejected a challenge by the pharmaceutical industry against Michigan for encouraging low-income patients to use lower-cost prescriptions. The Pharmaceutical Research and Manufacturers of America joined mental health advocates in arguing that a formulary is dangerous, as well as unconstitutional because the full state Legislature never considered the program. The state created its preferred drug list by identifying the most effective products in each of 40 therapeutic categories and automatically including on the list the least expensive of those medications. Drug companies can pay supplemental rebates to the state to include other products on the list, and doctors can prescribe medications not on the formulary with prior approval. The state Department of Community Health estimates that the formulary saves the state $850,000 per week. The ruling is "significant because a rapidly growing number of states have adopted preferred drug lists in an effort to control drug costs," reported the *New York Times*. NCSL says that 26 states are using drug formularies, and another 10 have enacted laws authorizing their use.

Reaching the Homeless

Enrolling the homeless in Medicaid is tremendously difficult for a number of reasons. First, most of the homeless are childless, single adult males or non-custodial parents under age 65, so they don't meet many states' Medicaid criteria. Also, 85 percent of the chronically homeless are mentally ill or have addiction or other major disorders, so the enrollment process itself can be a barrier. Finally, people can quickly lose their Medicaid enrollment by being jailed or admitted to an institution for mental disease. Nevertheless, a handful of states have made significant progress in bringing health care to the homeless, according to a new publication from the Centers for Medicare & Medicaid Services. Delaware, for example, estimates that 78 percent of its homeless citizens are enrolled in Medicaid. To achieve this level of coverage, the state first obtained an 1115 waiver from CMS; this enabled the state to extend Medicaid eligibility to impoverished uninsured adults without children or a disability. Delaware also waived the asset requirements for Medicaid, and the state employs a health benefits manager to reach out to people in community centers, clinics and other places where homeless people may be found. An estimated 2-to-3-million Americans experience a night of homelessness in any given year; some 400,000 to 600,000 are chronically homeless. The publication details how Arizona, Massachusetts, Maryland, Minnesota, New York, Texas and Washington expanded Medicaid access to this hard-to-reach population. Go to www.cms.hhs.gov/medicaid/homeless/

CHILDREN'S HEALTH

Antidepressant Use Grows

The numbers are still miniscule – but more and more children are being treated with selective serotonin reuptake inhibitors (SSRIs) – antidepressants such as Prozac. From 1998 to 2002, the overall prevalence of SSRIs among children 18 years old or younger grew from 160 per 10,000 children to 240 per 10,000. That's an annual increase of 9.2 percent. The growth rate was greater among girls (a 68 percent increase) than boys (a 34 percent increase). Medication among pre-school children remained tiny (less than one-half of 1 percent), but the percentage of medicated girls aged five and under doubled from 1998 to 2002, while use among preschool boys rose by 64 percent. Experts are divided on whether the drugs are being over-prescribed, or whether depression in children is finally being diagnosed and treated. The study appears in the April issue of the journal *Psychiatric Services*.

HEALTH CARE

Innovative Program Awards

The United Hospital Fund announced ten new grants (totaling $526,000) on March 12, to support innovative programs to improve health services in New York City. The grants are part of $3 million that will be distributed by the Fund this year to support promising new ideas and projects to improve health care for all New Yorkers. Four of the grants will be used to support projects to expand health insurance coverage to the estimated 1.9 million uninsured New Yorkers under the age of 65. The Commission on the Public's Health received $50,000 to develop a network of community-based organizations to collect and disseminate information on the health-care safety net in the Bronx, and Health Resources Inc. received $75,000 to analyze Medicaid eligibility, enrollment and claims information to find cost-effective ways to improve care for low-income New Yorkers. An additional three grants, totaling $160,000, will be devoted to strengthening the organization and delivery of health-care services. The remaining grants will fund projects to advance aging and chronic care services. For more, visit www.uhfnyc.org

Privacy Law Upheld

A Philadelphia U.S. District Judge on April 2 dismissed a lawsuit filed against the U.S. Department of Health and Human Services by physicians and consumer advocates seeking an injunction against privacy regulations published last April under the Health Insurance Portability and Accountability Act (HIPAA). The HIPAA Federal Privacy Rule allows health-care providers to share patient records for the purposes of treatment and other "health-care operations." Providers are not required to obtain written consent before they disclose medical information, but they must inform patients of their rights and make a "good faith effort" to obtain written acknowledgement from patients that they have received this information. Providers are required to obtain consent from patients in non-routine cases. Attorneys for the plaintiffs argued that the new rules are so broad that patients do not have a say in how their medical information is used or shared by health plans, billing companies, drug companies or consultants that do business with providers. But, the ruling judge argued that the plaintiffs had "failed to show that the regulations were enacted improperly or were unconstitutional," reported the *Associated Press* April 3.

Donating Cancer Drugs

Cancer treatment just got cheaper in Wisconsin. On April 6, Gov. Jim Doyle signed a law allowing families of cancer patients to donate leftover medications and supplies to hospitals and pharmacies who will redistribute them to patients who are uninsured or in financial need. While Ohio and Nebraska have similar laws in place, the Wisconsin law goes one step further by allowing for the donation of supplies, not just drugs, and allowing families (not just hospitals or hospices) to donate. The state Department of Health and Family Services will create rules for inspecting donated drugs to determine if they are in their original, unopened and sealed packages, and for eligibility requirements for receiving the drugs.

PUBLIC HEALTH

West Nile Virus

California public health officials have reported that two wild birds captured in Fullerton have tested positive for West Nile Virus. The cases are the first in the state and their early timing marks the beginning of what could be a dangerous mosquito season for the entire nation. As part of an early detection program, vector control biologists have set up traps around Fullerton to routinely catch and test birds. The virus, which usually causes no symptoms or mild ones such as fever, headache and nausea, first appeared in the U.S. in 1999 in the New York area. Since then it has crept westward causing 240 deaths nationwide.

Attack on Heart Attacks

New York is spreading the news: obesity, physical inactivity and smoking can kill you by causing cardiovascular disease. Gov. George Pataki recently unveiled a comprehensive program designed to persuade adults and children to be more active, make healthier food choices and quit smoking. The state plans to get employers and schools to make nutritious food items available in vending machines, promote coordinated school health programs, make communities more pedestrian-friendly, and promote farmers' markets and community gardens. The New York Health Department is making $683,000 available in grants for projects that will promote cardiovascular health among schools and youth and at the worksite. Some 700,000 New Yorkers die each year from cardiovascular disease.

Kicking Butts

Teens across the country joined a nationwide rally against tobacco use and advertising during the ninth annual Kick Butts Day on March 31. The event is coordinated by the Campaign for Tobacco Free Kids, and it aims to encourage youth leadership and activism. More than 1,500 events were planned for Kick Butts Day, including poster contests, unveiling of memorial walls to those who lost their lives to smoking-related illnesses, mock funerals for the Marlboro Man, wellness activities and petitions for making local sports events and eating venues smoke-free. Over one-quarter of U.S. high school students smoke, and roughly one third of them will die prematurely from smoking-related diseases. For more, visit kickbuttsday.org/

Just Talking the Talk

Most adults say they practice safer sex – but they don't. That's the upshot of a new survey conducted to mark April as Sexually Transmitted Disease (STD) Awareness Month. The survey of 1,155 adults aged 18 to 35 found that 84 percent said they take the "necessary" steps to protect themselves against STDs. But 82 percent of participants said they never used protection against STDs during oral sex, 64 percent did not protect themselves during anal sex and 47 percent did not use protection during vaginal sex. Also, although 93 percent of those surveyed said they believed their partners did not have STDs, about one-third said they had never discussed the issue with those partners. Participants had the least knowledge of hepatitis A and hepatitis B, both of which can be prevented with vaccines. For more, go to www.ashastd.org/aboutasha/index.html

ENVIRONMENTAL HEALTH

Protecting the Atmosphere

Maine's hospitals are making the switch, from burning to autoclaving. In an agreement applauded by environmental health experts, the 39-member Maine Hospital Association (MHA) plans to build a plant that will sanitize and shred nearly all of the state's medical waste. The plant will autoclave the waste, shred it and truck it to nearby landfills. The strategy is expected to save the hospitals money because they'll no longer have to haul the waste to Massachusetts to get it burned. But the plan also should protect the air Mainers breathe from the dioxins that are released into the atmosphere by the burning of plastic tubing and other medical supplies that contain polyvinyl chloride (PVC) plastics. "These chemicals have a whole range of adverse health effects," Mike Bellivue, executive director of the Bangor-based Environmental Health Strategy Center told the *Kennebec Journal*. "The strategy that Maine's hospitals have proposed will prevent dioxin and other toxic byproducts from entering the airstream." In 2001, the MHA, the state Department of Environmental Protection and the Natural Resources Council of Maine signed an agreement pledging to, among other things, virtually eliminate mercury from the hospital waste stream by 2005, and progressively reduce products and packaging containing PVC as part of an overall effort to reduce the use of bioaccumulative toxic chemicals.

LONG-TERM CARE

A Second Job

More than 44 million Americans provide unpaid care to another adult, sometimes at great physical, emotional and financial cost, according to a new study from the National Alliance for Caregiving and AARP. The national survey of 6,139 adults defined caregivers as adults who help other adults on an unpaid basis with tasks such as helping to manage finances, doing housework, bathing, and shopping for groceries. The typical caregiver is female, 46 years old and married, and provides care to a widowed woman, aged 50 or older. But it's not just women providing the care. Almost four in ten caregivers are men, and 60 percent of them work full-time. Three in ten caregivers carry an especially heavy load; these tend to be older women who say their own health is only fair. They tend to report more physical strain, emotional stress and financial hardship than do caregivers who provider fewer hours of care and perform less demanding tasks. The federally funded National Family Caregiver Support Program is providing $159 million to families in FY2003, and the Bush administration has proposed spending $161 million for FY 2005, according to *USA Today*. For more information on the study, go to http://caregiving.org

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In addition, the project awarded up to $500,000 to each of eight universities and centers in September 2003 for two years to conduct research and evaluations on workplace and public policy interventions. The demonstration grantees in the five states then will have a year to disseminate their findings.

Here is how the project is testing new approaches in three states: Iowa, North Carolina and Vermont.

IOWA

The average aide turnover in nursing homes in Iowa is estimated at 80 percent and is reported to be as high as 200 percent in some facilities. To chip away at these percentages, the Iowa CareGivers Association – one of the country's first independent statewide professional associations for direct-care workers in long-term care – along with a coalition of providers, state agencies and consumer organizations, received a Better Jobs Better Care grant. The funding will allow the coalition to expand and enhance the state registry of nursing assistants, study health insurance coverage and develop peer mentor training programs.

As required by federal law, Iowa's Department of Inspection and Appeals maintains a registry of certified nursing aides (CNAs) who work in nursing homes. However, the database currently does not include direct-care workers in other settings. The coalition is using its grant to include in the registry health-care aides, rehabilitation aides, medicine aides, personal care attendants and other personnel who work under the direction of a nurse.

The registry is designed to detect and monitor abuse. "But we're hoping that it will be a means to have a profile of these workers to determine the supply of workers and how many use it as a stepping stone to a career and how many leave after three months," said Di Findley, executive director of the Iowa CareGivers Association.

The grant also will allow the association to update a 2001 wage and benefits survey. "What we learned [in 2001] is that 70 percent of those surveyed said their employer offered health insurance, but 43 percent said they could not afford it," said Findley. "With this grant, we will repeat the survey and add more questions to find out how many are without coverage."

The association then will study the feasibility of offering health insurance to its members. "Some say that it would be cost-prohibitive for our association to provide health insurance to these workers because they are high risk," Findley said. For example, the workers often have to lift their clients, which puts them at high risk of injury and increases the cost of premiums.

Another grant initiative is to develop peer mentor training for direct-care workers. The association has recruited 11 nursing homes and 4 home-care providers to participate in an orientation program in April 2004. The mentor training was first piloted in nursing homes in 1998, and now with the grant funds, it is being modified for home settings.

CNAs in nursing homes are required by federal law to have 75 hours of training. This peer mentor training program would be an additional two days beyond the federal requirement. This program will "launch workplace culture changes to give clients more control and empower workers within the organization," said Findley.

While the grant dollars are crucial, the majority of the association's funding is from state and federal dollars. Legislators have been "very responsive to recruitment and retention and [have] appropriated dollars to our organization," she said. "They understand the importance of these issues because of the high numbers of older people."

Change is slow to occur, Findley acknowledged. But she pointed out that more than 80 providers requested applications and

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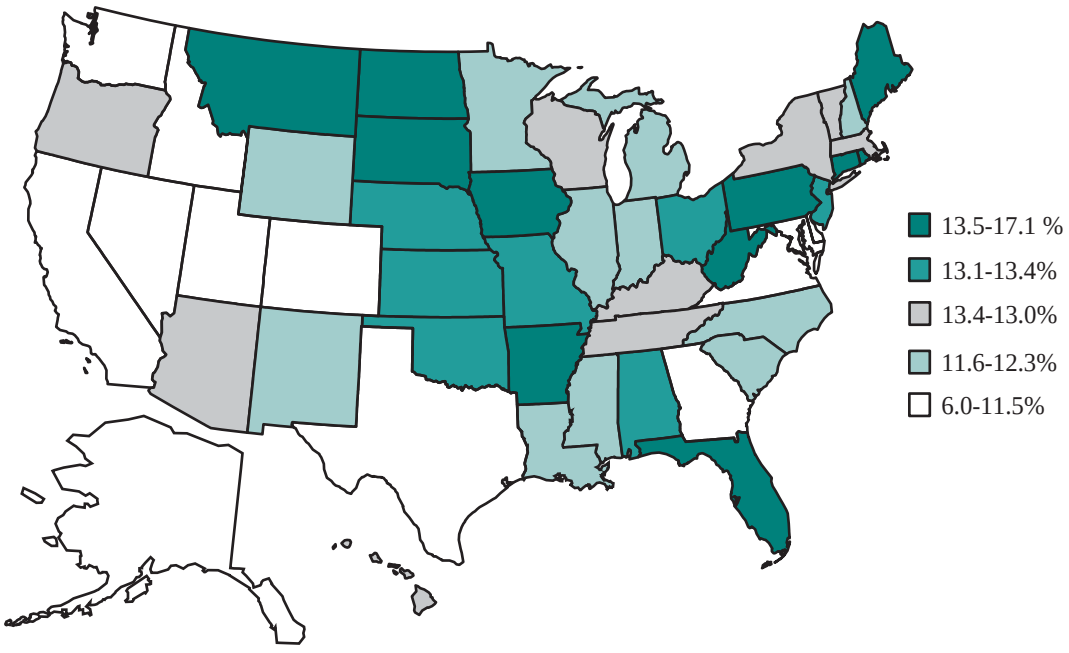
Persons 65+ as a Percentage of the Total Population, 2002.



Source: Administration on Aging, based on pooulation estimates from the U.S. Bureau of the Cenusus, 2002

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40 returned them to participate in the Iowa Better Jobs Better Care program. "That tells us people are ready for change," she said.

NORTH CAROLINA

In the Tar Heel State in 2002, the turnover rates for direct-care workers in home-care agencies averaged 39 percent; in nursing homes, 95 percent; in adult-care homes, 115 percent, according to the state Department of Health and Human Services and the University of North Carolina, which analyzed data from the annual provider licensure renewal process.

The significant shortage of direct-care workers has motivated the department to join a broad coalition of providers, workers, advocacy organizations and other state agencies. The coalition is using its Better Jobs Better Care grant to develop a voluntary, special licensing designation for home care companies, adult care homes and nursing facilities that have excelled in recruiting and retaining workers.

The coalition is hoping that facilities that obtain the special licensure will eventually be rewarded with increased Medicaid reimbursement, said Susan Harmuth, project director. But in the meantime, at the very least, the new licensure could "serve as a marketing tool for providers," she added.

During the first year of the grant, the coalition plans to create four major domains – balanced and safe workload, supportive workplaces, opportunities for advancement, and training – for the special licensure. During the second year, the state quality review organization will work with other state regulatory agencies to determine which providers meet the criteria. After a pilot period, the project is expected to go statewide by the end of the grant in December 2006, said Harmuth. Coalition members "will be able to compare turnover data from those providers who received the special designation with the state average," she said.

The state applied for the grant "to build off of some of the other projects in the state," said Harmuth. For example, the state is developing two new job categories for direct-care workers: medicine aide and geriatric nurse aide. Also, the state's "Win a Step Up" program provides financial and other incentives for workers who complete additional training and commit to staying with their current employer.

"The big thing is that we came together early with all of the stakeholders, and we're all looking at ways to address the shortage," said Harmuth. With the help of an outside facilitator, we are reaching consensus and moving forward, she concluded.

VERMONT

Like the coalitions in Iowa and North Carolina, the Community of Vermont Elders (COVE) – a consumer advocacy organization devoted to improving the lives of seniors – and about two dozen other organizations in Vermont had been working collaboratively for years to improve the direct-care workforce. A study commissioned by the Vermont Department of Aging and Disabilities found that the turnover rates range from 35 to 60 percent in nursing homes and home health agencies and are up to 400 percent in residential care homes.

The project is using its Better Jobs Better Care grant to expand quality criteria for nursing homes to include workforce measures, increase reimbursement for workers in residential care facilities and adult-day programs, develop licensure for personal care attendants and initiate a certificate of proficiency program for direct-care workers to receive specialized training.

The Vermont Department of Aging and Disabilities has a $125,000 fund to reward nursing homes that achieve success in four areas of quality, said Tim Palmer, COVE's executive director. Through the Better Jobs Better Care grant, the state will now "add a fifth criterion that will gauge recruitment and retention of direct-care workers," he said. Out of a total of 44 nursing homes in the state, up to five nursing homes will receive $25,000 in 2005 based on how well they meet the five criteria.

COVE also has been working to increase reimbursement especially for residential care facilities and adult-day programs. COVE members have been testifying before various legislative committees that these workers should be paid more on par with workers in other long-term care settings. Vermont is one of the few states that has a budget surplus, and last year, the state increased funding for residential and adult day care by $100,000, Palmer said.

This year, the budget has not yet been approved, but the House Appropriations Committee has approved another increase for both types of providers. "There is a willingness on the part of the legislature to invest in those aspects of the long-term care continuum that support older Vermonters to stay at home," commented Palmer.

Personal care attendants in Vermont are not licensed by the state right now, so the coalition also is developing a consistent definition of the training and skills that a personal care attendant should have, said Palmer.

Finally, the project is creating a certificate of proficiency program through which direct-care workers in fields such as mental health, dementia and Alzheimer's, hospice, palliative care, and/or rehabilitation can receive specialized training and then be compensated at a higher level. COVE will begin issuing the certificates in early 2005, but members hope that a statewide entity will eventually take over. That way, the certificates "can be generally available and acknowledged in the industry across the state," Palmer said.

Referring to the state's small size and the large number of grant initiatives, Palmer said he thinks Vermont was chosen for the grant because "what appears to be a small investment goes far here."

Lipson summed it up: "This field has been so neglected and so ignored for so long. Even in the midst of [most states] cutting back, we hope this [project] will make a better case for investing in this workforce." *+WFG*

For more information on Better Jobs Better Care, go to www.bjbc.org.

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Published biweekly (24 issues/yr.) by the FORUM FOR STATE HEALTH POLICY LEADERSHIP, an information and research center at the National Conference of State Legislatures in Washington, DC.

For more information about Forum projects, visit our web site at: www.ncsl.org/programs/health/forum

RESEARCH & EDITORIAL STAFF
Dick Merritt — Forum Director
Christina Kent — Managing Editor
Anna C. Spencer — Associate Editor
Contributors: Allison Colker, Donna Folkemer, Wendy Fox-Grage, Shelly Gehshan, Tim Henderson, Michelle Herman, Diana Hinton, Kala Ladenheim, Greg Martin, Anna B. Scanlon

EDITORIAL INQUIRIES

Christina Kent, Managing Editor
Tel: 202-624-5400 • Fax: 202-737-1069
email: christina.kent@ncsl.org

CUSTOMER SERVICE & SUBSCRIPTIONS
NCSL, 7700 East First Place, Denver, CO 80230
Tel: 303-364-7700 • Fax: 303-364-7800

TRACKING *TRENDS*

From NCSL's HEALTH POLICY TRACKING SERVICE

Cost Concerns Slow Drive for Parity in Mental Health and Substance Abuse

2004 started out looking like it would be a good year for parity in mental health and substance abuse treatment. As of March 22, 32 state legislatures had introduced bills requiring insurers to cover mental health and substance abuse treatment to the same extent that they cover treatment for physical illnesses.

But that momentum has slowed. Although parity legislation passed the chamber of origin in ten state legislatures, only Virginia and West Virginia ended up enacting laws. Moreover, West Virginia made technical, not substantive, changes to existing law.

The current lack of enthusiasm contrasts with prior legislative sessions. In 2002, eight state legislatures passed bills providing parity for either mental health or substance abuse treatment or both. Six legislatures did the same in 2003.

In the current economic climate, lawmakers appear to be wary of any new government mandates on the private sector -- especially if those mandates will increase health insurance costs. Critics of parity laws point to research such as a 2002 study that found government mandates accounted for $10 billion of the $67 billion increase in health insurance premiums between 2001 and 2002. Advocates of parity say equal treatment ends up saving dollars and lives by ensuring that people who need assistance, get it. Patients who are treated can continue working and contributing to society, they say.

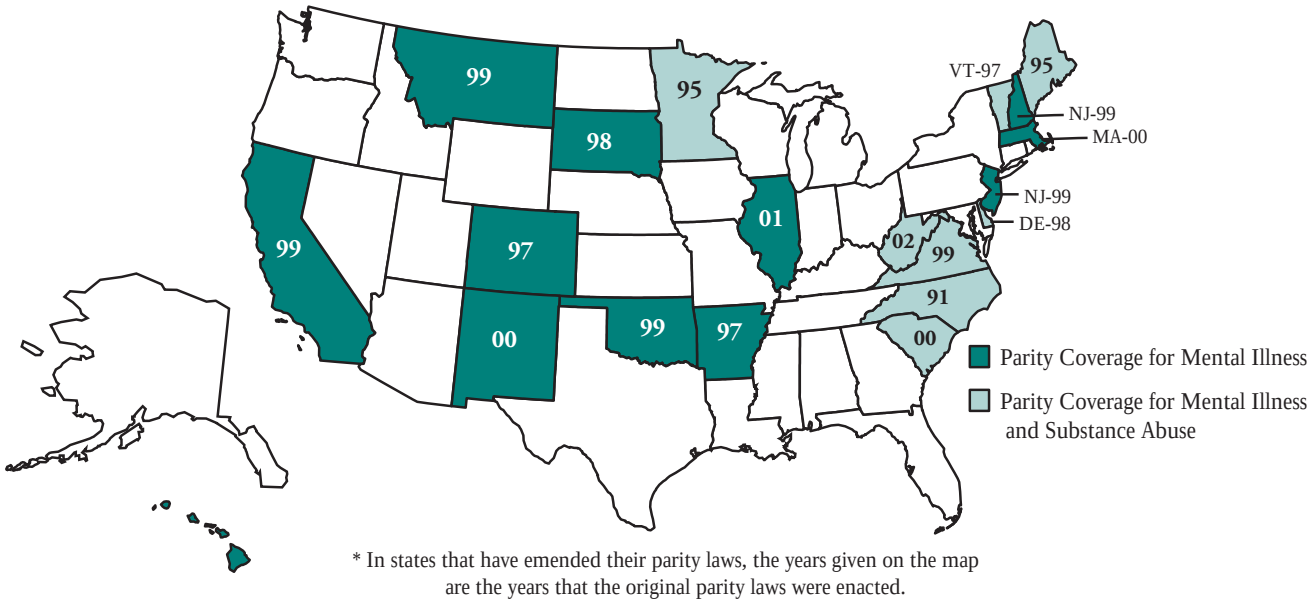
In some states, the battles over parity have been fierce. In New York, the Assembly passed AB 8301 (which would have required insurers to offer the same level of benefits for mental health and substance abuse treatment as for other illnesses) by a 131-10 margin.

However, Senate leaders were expected to block passage because of fear that the bill would increase premiums. Bill sponsors said they'd try to gain support by exempting small employers from the mandate.

In Washington, the sponsors of parity legislation HB 1828 sought to win support by explicitly excluding employers with fewer than 50 employees from the mandate. But the Legislature adjourned prior to a Senate vote. *AM*

For more information on this topic call (703) 531-1213 or e-mail info@hpts.org

STATES THAT HAVE ENACTED FULL PARITY LEGISLATION



* In states that have emended their parity laws, the years given on the map are the years that the original parity laws were enacted.

FOR YOUR *INFORMATION*

Breaking the Chain: Mentoring Kids Whose Parents are in Jail

Studies show that children with incarcerated parents are seven times more likely than the general population to become incarcerated themselves. They often experience school difficulties, hyperactivity, attention deficit and conduct disorders, as well as anxiety and financial insecurity. Mentors, who offer a consistent and positive role model to children whose parents are in jail, may break the cycle of intergenerational incarceration.

In recognition of this, the University of Maryland has teamed up with two local organizations to start a first-of-its-kind mentoring program for children in Washington, D.C. who have a parent in jail.

Called Breaking the Chain, the program was launched in October 2003 as part of a $9 million federal initiative that is aimed at providing disadvantaged youth with support as they grow into adulthood. Fifty-two organizations throughout the country received federal money to implement mentoring programs, which are being administered by the federal Administration for Children and Families.

The need for assistance to these children is great, and not just in the District. Between 1991 and 1999, the number of children with a parent in a federal or state correctional facility increased by more than 100 percent, from about 900,000 to 2 million. Fewer than 50 percent of prisoners receive regular visits from their children, either because the children's caregiver chooses not to visit or because the distance is prohibitive.

Breaking the Chain is a three-year, $120,000 collaboration between the Center for Substance Abuse Research (CESAR) at the University of Maryland, the Maryland Mentoring Partnership (which has launched more than 300 mentoring programs across the state) and the Breaking the Chain Foundation, a non-profit organization that provides services to children who live in the District of Columbia and who have a parent in jail or on probation.

Seventy-five youths with an incarcerated parent will be recruited by Breaking the Chain to participate in the program. The youngsters will be referred by parents, caretakers, schools, courts, social services agencies, as well as religious organizations in the Southeast district of Washington, D.C. where it's estimated that there are 2,000 children with an incarcerated parent. The children, aged 4 through 15, will be matched with mentors who will be recruited from community and church organizations, the local chapter of the NAACP and the National Council for Negro Women.

Mentors will be required to make at least a one-year commitment to the program, and to meet at least once weekly with his or her mentee. They also will be encouraged to form a relationship with the whole family in order to ease the transition when the incarcerated parent is released.

Mentor training is being be coordinated by the Maryland Mentoring Partnership. After being screened for appropriateness, each mentor will receive training on all aspects of youth development, including techniques for establishing trusting relationships and special needs of children of prisoners. Mentor/mentee matches will be supervised and evaluated on a periodic basis to ensure that participants meet the requirements of the program, and that the relationships are satisfying to both parties.

Mentoring children in this population "poses some very unique challenges for both mentors and program coordinators," says Amelia Arria, director of clinical research at CESAR. "These children come from very complicated family situations, and some have had very little exposure to a lasting and trusting adult relationship." Mentors will provide one-on-one time with children who have probably had "very limited time with a dependable, trustworthy role models."

The mentors will provide exposure to opportunities such as restaurant and event outings, as well as provide "guidance to kids in finding out where their strengths and interests lie," Arria said. Connecting children with mentors "at this critical time in their lives should have a lasting positive effect," she added.

To date, there has been limited research into the mental health and social service needs of children with parents in prison, Arria noted. So Breaking the Chain is expected to not only provide a valuable community service, but to present an opportunity for researchers to "better understand the needs of children with parents behind bars," Arria said. *ACS*

For more information about the program, visit www.cesar.umd.edu, or call (301) 405-9770. For more on the Maryland Mentoring Partnership, visit www.marylandmentors.org

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FORUM FOR STATE HEALTH POLICY LEADERSHIP
National Conference of State Legislatures
444 North Capitol Street, NW, Suite 515
Washington, D.C. 20001